THE PUBLIC'S CONCERN WITH QUALITY OF MEDICAL CARE*

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THE New York Academy of Medicine has, through the years, called attention to many aspects of medicine "affected with the public interest" before these became matters of obvious public concern. It is a worthy, and often strenuous, task in which I gladly join. Certainly, the decision to focus this year's programs on the quality of medical care is in keeping with this tradition.

It will be my purpose to review what is and is not being done to achieve and maintain high standards of quality in medical practice and to hazard some opinions as to the future course of these efforts.

While I shall make some local references, it should be clear to all that this is a well-nigh universal and not a purely local problem. The realm of the possible in medicine has been expanding rapidly. Both the need to compare the actual with the possible and the skills to make this comparison are greater than ever before.

QUALITY AND ITS MEASUREMENT

Inherent in the concept of quality is this comparison of an actual unit of service with some standard consistent with the current state of medical knowledge. There is a growing literature on how this comparison can be made with sufficient precision to produce results that can be independently duplicated. All such measurement methods involve a retrospective review of the care given during one or more illnesses, or, if prevention and rehabilitation are to be considered, to one or more patients during a period of time.

Since the review is retrospective, and since much medical care is given in circumstances of immediacy, the reaction of the treating physicians is often a natural impatience with second-guessing and the omniscience of hindsight.

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The most useful of such methods have a statistically valid base and test the care under review against predetermined criteria of excellence. The infinite variety both of humans and the ills that plague them make this evaluation difficult when a single case is considered. Nevertheless, even the single case review is done regularly in the clinical-pathological conferences of good hospitals with highly beneficial results both for patients and medicine.

However, when a suitable statistical universe of cases is measured against valid predetermined criteria of quality, a body of fact builds up that cannot be shouted down. There is a growing body of such fact, mostly concerning in-hospital care. Medicine should be aware of, and increasingly familiar with, this growing body of knowledge. It reveals facts that cannot escape public attention and thus have political as well as professional implications.

In general, these facts substantiate what many knowledgeable practitioners and medical administrators have known and worried about for years. The legal right to practice medicine is vested in a group of individuals who vary widely in their natural ability, training, and dedication. The results of their work vary through the broad range of the near miraculous to the downright shoddy.

Similarly, the quality of care rendered in individual hospitals shows wide variations that reflect not only the collective excellence of a medical staff, or lack of it, but also the effectiveness of the institution's efforts to select a qualified staff, to create a climate of excellence to stimulate it and to enforce compliance with valid standards of performance.

These variations exist. The knowledge of their existence is spreading far beyond purely professional circles. We should not be surprised when society seeks to defend itself against the reckless or inept practitioner and the loosely administered hospital.

Economic forces have focused the attention of labor, management, public regulatory bodies and legislators on the need for controls on the cost, use, and expansion of hospital facilities. Much of this attention is well-intentioned but uninformed. It may even endanger the public health unless it results in controls so applied as to not endanger quality. Thus, the need to deal administratively with issues involving quality of care requires that, to the greatest extent possible, our actions be based on demonstrable fact and not upon unsupported opinion. Ac-

cordingly, the ability to measure quality of care becomes crucial.

In general, four types of approaches have been taken to the measurement of quality. The method in longest use is the review of the individual case history by a person or group of persons presumed to be competent to exercise judgment as to the quality of the care given.

One example of this type has already been referred to as the clinical-pathological conference where the case review is used primarily as a teaching mechanism. Another variation is the medical audit in which the histories of a selected sample of cases are reviewed, usually with special reference to the recorded evidence supporting the diagnosis made or the treatment ordered. Obviously, such judgments tend to be subjective and results are heavily influenced by the person or persons doing the reviewing.

The second general method might be called the "circumstantial evidence" approach. In this instance, a body of detailed data is collected, classified, and analyzed to discover meaningful variations in practice among individual physicians, hospitals, or clinical divisions. Perhaps, the largest volume of this type of work is carried on by the Commission on Professional and Hospital Activities in Ann Arbor, Michigan. It is of great help in identifying within the total summary of, say, a year's work by the staff of a single hospital, the particular segments of that record which may warrant more detailed analysis. While this approach can occasionally reveal gross departures from accepted practice—long-term stays of diabetic patients during which no blood studies or urinalyses were done, for example—it largely reflects departures from the norm and thus attaches greater significance to the norm than may be warranted.

The third general approach is to study results achieved over a period of time. This has been most widely used in the public health field because of its obvious usefulness in studying the success of preventive measures, mass screening programs, etc. It has the inherent difficulty of all time studies of human populations, namely, the bias introduced by the in and out migration of the population under study.

The fourth general approach is perhaps the most precise and revealing. Under this, physicians of acknowledged competence in a particular area of practice establish specific criteria of good practice in the care of specific illnesses. Having established such criteria, the records of a valid statistical sample of all the patients cared for by an individual

physician, by a hospital, or one of its departments, or of all patients cared for under some administrative or fiscal program, are then evaluated against the previously established criteria. If resources permit, the review can include an interview with the treating physician to expand on the written record. This method is difficult and costly to apply because predetermined criteria have been developed for only a few conditions. Hopefully, however, the objectivity of this method will encourage its further use and the development of accepted sets of standards, at least for all of the conditions which represents any sizeable proportion of hospital use. Were such standards currently available, there are many opportunities to apply them promptly at relatively little additional cost. Because they are not available, the immediate application of this method to any large segment of hospital practice would represent a major expenditure of time, effort and money.

The Roots of Quality

Efforts to enhance and maintain quality usually involve an attempt to eliminate obviously bad practices, an attempt to improve the over-all average and, occasionally, attempts to raise sights as to the peak performance possible. Enforcing a minimum standard, upgrading the general level of practice and demonstrations of excellence, each have their place in improving quality.

Minimum standards can be policed. However, optimum performance in medicine as in all human endeavor, cannot be enforced. It must flow from self-determined aspirations pursued in a climate of achievement. Such superior performance is sometimes attained and maintained by solo practitioners and in groups of various types. It is most consistently attained in the great teaching centers where the students, teachers, scholars, facilities, tradition, and patients are concentrated in the "goldfish bowl" atmosphere that characterizes the best of them and produces a whole that is greater than the sum of its parts. Even the greatest of the teaching centers struggle against two primary threats to quality—their usual organization pattern makes continuity of patient care difficult, and their resources are unequal to the demands society makes of them.

Without doubt, the tap root of quality of medical care is the standards which medical education in this country has largely imposed on itself. Supplemented as this is by our postgraduate medical education

program, the best medical care available in this country is probably close to the best humanly possible in the light of current medical knowledge. But this is not cause for complacency. There is evidence that a significant portion of medical practice is at levels below the best medical care available.

Many voluntary efforts by the profession and by hospitals make substantial contribution to maintaining the quality of care given all classes of patients. Notable among these are the specialty boards, the hospital accreditation activities and, what business would term, the internal audit program of a good hospital medical staff represented by its tissue committee, its educational program, its department of pathology and, more recently, the utilization committees.

Only the elemental steps have been taken to enforce continuing compliance with minimum standards. State licensure, of both medical practitioner and hospitals, is almost the only absolute.

Another safeguard of quality, not widely recognized, is the process by which hospital staff appointments are granted or withheld. For the most part, final authority rests with laymen who have no monetary interest in the decisions made and who are becoming increasingly skillful in securing professional help in making the judgments for which they must accept responsibility. Undoubtedly, there are instances where sympathy or the less noble qualities of cowardice, callousness or connivance, have resulted in hospital staff appointments being made or refused for reasons other than the competence and character of the appointee. Nevertheless, the authority and the responsibility of the individual hospital to select its medical staff and to define the limits of its practice within the institution, is a fundamental bulwark of quality of care.

Further development and wide application of precise and objective methods of measuring quality of medical care will give the best assurance to both the profession and the public that such appointments are made for reasons consonant with sound public policy.

The growth of prepayment agencies has given a large segment of the public a very immediate interest both in the quality and the cost of health services. This interest is now widespread among labor and management, public regulatory authorities, and the prepayment agencies themselves of all types, the community service agencies, such as Blue Cross, the self-insured health and welfare programs operated by labor,

management and jointly, and the private insurance companies. Such agencies are beginning to learn what many of us have known for a long time—that the lowest total cost for health service is often achieved by availing oneself of the best possible care at the earliest possible moment.

In view of the economic resources of prepayment agencies and their economic interest in quality, we may expect them to be increasingly concerned with and active in efforts to improve the quality of medical care.

The Current Local Scene

Both the general public and all of us concerned with health and hospital services will, in the years immediately ahead, be hearing more about both the costs and the quality of medical care. Responsible segments of labor and management have established the New York Labor-Management Council of Health and Welfare Plans and retain the services of an able, experienced executive. A joint labor-management group of trustees of Teamster Health and Welfare Funds have spent more than eighteen months educating themselves on the problems associated with the costs and quality of medical care. These are more statesmanlike expressions of consumer interest than are often shown in this emotionally charged field which touches the consumer at two of his tenderest spots—his health and his pocketbook.

The recent Columbia University Survey of medical and dental prepayment plans has triggered some chain reactions that will probably yield a measurable fallout for some time to come. Some of the immediate professional reaction to the Columbia Survey findings seems to center around their validity, particularly those related to unnecessary hysterectomies. Perhaps the reaction is natural since it is unusual to find such matters dealt with authoritatively in the public press. But frankly, it is surprising that this comes as any shock to responsible elements of medicine. As long as six years ago, the Journal of the American Medical Association published a carefully documented article which showed that in one community, the incidence rate of hysterectomies dropped from 3.7 per thousand population per year to a rate of 2.1 hysterectomies per thousand population per year after a medical audit program was reasonably well established in two of the community's major hospitals. There are similar facts which can be adduced

in other areas of medical practice. It seems certain that there will be increasing nonmedical concern with and participation in the administration and finance of health service. The social, economic and political forces all suggest this as the likely course of events.

Next Steps

Faced with this growing body of fact and increasing public awareness of it, the question becomes—what should be done?

The tools society uses to assure itself of essential services are of three general types—legislative prohibitions, public regulation, and voluntary effort. All three methods are already in use and each has adherents who would put primary reliance on one to the exclusion of the other two. The next decade is likely to see some extension of all three methods as they apply to health service. Let us hope that each is used only for the purpose for which it is adapted and in ways which in their long-term total result actually do improve total quality. Because both the profession, hospitals and the prepayment agencies have special responsibilities and opportunities in the use of voluntary methods, it is in this area that I shall make my specific suggestions.

An increasing proportion of the total of medical care is rendered in, and in association with hospitals. For that reason, and because hospitals have an established working pattern of relationship with medicine, I believe the most immediate results can be achieved by the medical staffs, administration and boards of hospitals. Since many laymen tend to confuse the physical structure of a hospital with its institutional entity, it may be well to note parenthetically that, as here used, the hospital means an institution comprising an owner which may be a unit of government, a community service corporation, or an individual or partnership of physician licensees. This owner of the hospital controls the use of the physical facilities and equipment by a medical staff of the owner's selection. It does this by the establishment of policies, rules and regulations in consultation with and on the advice of the medical staff and through administrative procedures carried out by the administrative staff of the hospital responsible directly to the owner. In most hospitals, a great deal of authority is delegated to the medical staff for the discharge of responsibilities relating to the quality of medical practice within the institution. Nevertheless, legally, the institution, as a corporate, private, or governmental entity, has the ultimate

responsibility for the policies of the institution and the selection of persons who carry them out. Increasingly, institutions are being held legally liable when it can be shown that due care was not exercised in this selection process.

Therefore, it is abundantly clear that while practicing in a hospital, the individual physician is functioning within an organizational structure. It is a structure that is developed for the purpose of providing care to patients. It is within that structure that, I believe, the greatest opportunity lies for raising the level of medical care in the reasonably near future. Legislation, public regulation, external pressure groups, professional standard-setting agencies, all have a part to play, but I believe they are more likely to lower rather than raise the standard of care unless these other forces in society recognize that medical care rendered within the hospital organization can be influenced most constructively by making the functioning of the hospital organization more effective rather than by independent external action. Many persons responsibly interested in medicine have little hope of achieving effective results through such means. Often, the tendency is to seek some sweeping solution of legal or executive action which will solve everything. This is naive. The problems we are concerned with are those of human behavior of physicians in matters that can fundamentally influence their way of life—human behavior of patients in circumstances that could potentially, and might actually, involve their very life.

I can only conclude that the most constructive approach to matters of quality of medical care is at the individual institutional level. This will require mutual respect and joint effort on the part of hospital boards, administration and medical staffs. This very often exists in high degree. It must be brought into being in all hospitals. As a total institutional entity, the hospital may expect and should welcome being held accountable for responsible performance. Increasingly, it may expect such accountability to be asked of it by standard-setting agencies, by prepayment agencies, and by public regulatory bodies. If informed public servants or responsible legislators become convinced that these institutional responsibilities for quality of care within the institution are undischarged, they will find large segments of the public ready to be aroused to punitive action by scare headlines. It is a sad fact that most of such punitive action will have little direct effect in improving the quality of care. Yet, we are dealing here with stimuli-

response reactions in the body politic just as predictable as a normal knee jerk.

Before closing, I wish to comment on two important related matters not directly related to the thesis I have been presenting.

The growing enthusiasm of patients and certain of their legal counsel for malpractice litigation is both a stimulus and a threat to quality of care. I am not competent to judge on which side the balance will fall. I know only that the best medical care flows from a patient-physician relationship involving large elements of mutual respect and confidence. Good medical care is a service and not a commodity. Only rarely can it be provided to patients without some degree of patient participation and cooperation. The current wave of malpractice suits certainly impedes the development of sound patient-physician relationships and reflects some existing weakness in these relationships.

Much of the foregoing discussion has concerned itself with in-hospital care. This is not to underestimate the problems inherent in the quality of medical care in out-of-hospital practice. These are, however, not susceptible to such direct immediate solutions as are proposed for in-hospital care. The same forces are at work with respect to home and office medical care. However, the logical focus for efforts to improve such care is not nearly so obvious and in this area I defer to someone wiser or more imaginative.

In closing, let me emphasize again my belief that the public is becoming more informed about and concerned with the quality of medical care. This public concern represents a social force of considerable magnitude which, with irresponsible or uninformed leadership, can lower the quality of medical care or, with constructive guidance, can improve the quality of medical care. Action will undoubtedly be taken on a number of fronts: legislative, regulatory, and voluntary. There is much that physicians, hospitals, and prepayment agencies can do beyond what is now being done. Our limited resources of time, energy and money had best be devoted to bringing fact and objectivity into full play in making the value judgments inherent in judging quality, and having arrived at these judgments, to act upon them.